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ABSTRACT

This paper describes the continuum of comprehensive services offered by the social work department of the Long Island Jewish Medical Center to a high risk elderly population, i.e., those who are widows, widowers, older divorced individuals and singles, particularly those who have difficulty caring for themselves. Following a brief review of the literature dealing with the frail elderly, the Center's programs are described including the Enriched Housing Program (an alternative housing and support program in the community); a day care program providing medical monitoring and a socialization and activities program; and an advocacy program. The process of gaining support for the programs is briefly described and the advantages of the program approach are discussed. (MCF)

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The Medical Center's Impact as A Vital Force in A Network to Sustain The Aged in the Community

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The Medical Center's Impact as A Vital Force in A Network to Sustain The Aged in the Community

A process is described to show how a Social Work Department of a Medical Center ascertained the need to offer a continuum of comprehensive services to a high risk elderly population. This includes aiding and participating with the board and administration of the Medical Center to develop a varied network of services programs. A community based program model is used to show the utilization of individual and group modalities in working with this age population. Clinical material is incorporated to emphasize that aging clients are accessible for psychosocial interventions and can utilize their ego strengths through group living and group counseling. Experiences will highlight that behavioral changes can be brought about through a reintegration of social, emotional, and environmental forces.

The Medical Center's Impact as A Vital Force in A Network to Sustain The Aged in the Community

To meet the problem of the elderly who no longer find themselves involved with families - widows, widowers, older divorced individuals and singles - particularly those who are experiencing great difficulty in caring for themselves, various arrangements need to be developed.

Very often this group represents a high risk elderly population who require more medical and social services than other groups in the community. It has been found that the most evident vulnerabilities facing the aged are those socially related issues such as a loss of spouse, loss of peers who seem all too rapidly to die, move away or enter institutions, loss of family supports because of either physical or emotional distancing. Feeling vulnerable and isolated many elderly begin to exhibit physical symptoms and they look toward the Medical Center and frequently wind up in the emergency room for social rather than medical needs. (Peck, 1978)

Because the elderly are such a vulnerable group, the amount of psychological and physical energy involed in seeking help frequently deters them. Usually when they turn to the Medical Center their requests for help are not due to an awareness of emotional stress, but rather because of external factors, some of which are listed above, and in addition a change in environment caused by neighborhood deterioration or a housing crisis. (Lawton, 1977)

Housing and alternative living arrangements for this high risk group is a high priority for many elderly. The facilities currently existing offer little in

the way of services or of human social supports for positive group experiences as well. Often the facilities themselves, except for smaller group residents, become a gathering place in which old people vegetate. This elderly group may pass the time of day as idle observers and there are few professional services which bring stimulation and interaction to this group.

Few elderly voluntarily wish to choose this kind of living. However, many are reluctant to live with children and their young families, particularly since their children have moved from the extended family life style to a nuclear family and many elderly have become accustomed to living on their own.

The Medical Center is cognizant of the facts that this group, because they require more medical and social services, use Medical Center facilities to a larger extent proportionately than many other groups. Recent statistics published in the Journal of Gerontology (Rubenstein, Rhee, Lane, 1982) indicate that 11% of the population who are over age 65, utilize 30% more of the health care dollar and account for 36% of all hospital days.

Gerontological research over the last two decades has expanded our knowledge and understanding of the ever increasing elderly population. Much has been written about the demographics, the myths and stereotypes and the probability of physiological and psychological changes that take place as we get older. To meet the needs of a very varied group - young older, old older and the more fragile, dependent olds - there is a need for different life styles, environmental supports and a recognition that there should be a better, integrated system for community care. Hospitals, as the provider of health care services, have an important role in extending the health care system into the community. (Schaie, 1980, Silverstone, 1980)

Butler in discussing how people can be kept at home points out the importance

to older persons to live in homelike setting even when they become more frail. While hospital services are essentials, the high priced medically oriented concepts of care, is not necessary or therapeutic for those needing long term care. A homelike atmosphere and the ability to maintain a sense of autonomy and control is very important to the elderly. (Butler, Lewis, 1982)

In addition to our empirical experience, it was necessary to develop data which could be brought to the attention of the administrative, medical and decision-making bodies in the Medical Center, not only to acquaint them with these facts but to enlist their aid in helping to develop a varied network of services programs which would meet the needs which the economic and psychosocial problems of this group were creating for them and for the community.

With this in mind several complimentary programs were developed at the Medical Center, chief among them a supportive and psychosocial congregate living program for the frail elderly who required alternate housing and support programs in the community. The purpose is to provide a significant alternative to nursing homes and health related facilities for those elderly whose frail condition places them in jeopardy of no longer providing for themselves independently in the community.

A second program is a day care program in a nearby community center which provides medical monitoring for the frail elderly, a socialization experience and activities program. This program is another level of care in the continuum of services for the long term care needs of this population.

A third program is an advocacy program. There is on the part of present Federal administration much more strigent requirements regarding governmental benefit programs and this has resulted in more stringent eligibility requirements.

Many who are qualified as beneficiary of these programs, particularly those over the age of 65, have either been intimidated or unable to exercise sufficient initiative to take advantage of some of these programs of which they are eligible. An advantage to the hospital is that by providing these benefits to the frail elderly, they are able to reimburse the hospital for health, medical and social services.

When these programs were put together, the Administration was able to note that they represent a cost effective service and, in addition, develop linkages to the community. The Medical Center is providing much needed services for a population with which the community is particularly sympathetic.

The process began with a presentation to the Social Service Committee of the Board of Trustees in which these proposed programs were detailed and the support of the Board ascertained. Simultaneously the various medical departments involved in providing such services were contacted and their support solicited. This support came without difficulty because the Chairman and the physicians and nurses involved in these departments recognized that resources were becoming scarcer as the needs and number of elderly was rapidly rising.

With support of the medical departments and the Social Service Committee of the Board, presentation was then made to the Administration of the hospital through the hierarchical echelons and approval received for proposals to be developed jointly with the affected departments. These were then presented to various governmental and private funding agencies for support.

In the course of describing these programs and enlisting support, information pertaining to the needs of the affected populations was given and case

illustrations developed which could highlight the needs of this population as well as providing a description of potential resources which could be developed.

Although there was initial resistance and questions were raised concerning the role of the Medical Center in a network which was primarily Social Service in character rather than health, the decision-makers in the Medical Center began to view these programs as extensions of preventative and community medicine. Indeed, as these programs began to develop, the Medical Center began to encourage the Social Work Department and other departments involved to develop funding mechanisms through applying for grants which would expand these programs.

The resulting alliance amongst Administration, Board of Trustees, and the medical departments is of course very gratifying. It indicates the sensitivity of the Medical Center to the needs of this particularly high risk aged population and also alerts the community to the knowledge that the Medical Center wishes to be and is indeed a vital force in a community of social and health supports for aged.

Evidence of the support which the community gives in return to the hospital is the very large attendance that occurs at community seminars for the laity. Discussions, information and dialogue takes place between members of the community and the hospital professional staff regarding the availability of resources for the aged, problems experienced by families in dealing with their own aged members, the criteria for admission into the programs that the Medical Center has developed for this population, and to bring to our attention ideas for various other programs which may be developed in the future.

Our decision to develop the concept of an Enriched Housing Program as one of our first major community based programs was for a number of reasons. The first is that inpatients, over 65, were increasing at a rapid rate. Frequently, discharge

planning became a problem because many were unable to reside in the community without support.

Housing was seen by the Social Work Department as one of the most pressing needs for the elderly. Many did not require a hospital bed, but there were not adequate resources in the community, despite all of the rhetoric of governmental agencies and their cost containment policies. These policies did not and have not produced enough housing resources for the frail elderly. It also meant existing housing stock would be used and the elderly could continue to be integrated into community life.

It was projected that an Enriched Housing Program for this target population would result in a diminished use of the Emergency Room which, in some instances, is used for psychosocial reassurance because the elderly have no where else to turn. Helping the frail elderly remain out of institutions was another objective. Not only was it seen as more cost efficient, but would improve their functional capabilities, regarding physical and emotional decline. For some elderly, institutionalization can mean the unnecessary end of the road. That is not to say that institutions such as Health Related Facilities and Skilled Nursing Facilities are no longer needed.

The concept of the Enriched Housing Program is to simulate as closely as possible independent living in the community but with a support system for those who are no longer able to maintain their own home or apartment. We have provided an attractive physical set-up in a graden apartment development near good community services and commercial businesses. Each resident has an individual bedroom and shares the common areas such as living room, dining room, kitchen and bathroom. This affords the opportunity for privacy as well as companionship of other residents in a family atmosphere.

At present, we have five apartments of varying size for a capacity of 21 residents. Each apartment has a homemaker six days a week. It is the homemaker's responsibility to do all the marketing, meal planning, preparation and clean-up. Residents are able and encouraged to participate in all these activities with the homemaker to the extent of their ability and interest. Every resident manages to participate on some level. Although the homemaker has the responsibility for keeping all common rooms clean, residents are expected to take care of their own bedroom and, once a month, heavy cleaning is supplied by the program. We encourage residents to be as independent as possible in carrying out chores for themselves including use of the laundry room. The homemaker is there to assist those residents who may not be able to manage laundry on their own.

The program provides 28 hours a week of clinical social work time which is mainly devoted to working with residents individually, and , in groups, and with family, when necessary. Overall coordination and administration of the program is by the Project Coordinator, who together with the social worker, shares the screening and assessment process of all prospective applicants. In addition, there is an Apartment Manager who does the homemaking for a small 3 bedroom, 3 resident apartment as well as supervises and coordinates the work of the other homemakers. She also takes responsibility for meeting emergencies of the homemakers as well as resident weekend emergencies. Weekend emergencies were much more frequent in the early stages of the program and are, three years later, rather infrequent - the concept is working.

To add to the supports already mentioned, the program has the back-up of other hospital services such as the Ambulatory Care Clinics, and Home Care services when needed. Another service in the continuum of care, the Medical Center offers to older adults, which was mentioned earlier, is a Day Center for the

Frail Elderly at a neighborhood "Y" not far from our Enriched Housing Program. Several of our residents now participate a day or two a week in that program. Residents have also been helped to become involved in various community activities in churches, synagogues and senior centers. A volunteer visiting craft program has been a special success, since the participants are involved in making things needed by patients in the Medical Center.

In addition to the direct clinical work provided by the social worker, there is also help with planning and coordination of concrete services such as applications for SSI, Medicaid, banking and financial matters, transportation, monitoring medication, medical appointments and follow-up when necessary. Protocol for emergencies are clearly established as well as linkages to the local police emergency and ambulance corps.

It may seem from this array of services that resident autonomy and independence status are difficult to maintain. It is true that because of the nature of this protective environment, and support system, some dependence is fostered. Many of our residents who were growing up in the early part of the century, some native born, some as immigrants, experienced emotional and physical deprivation. Many struggled to establish themselves, work, marry, have families, watch children grow, leave the nest and once again, they are alone and struggling to maintain themselves. Now many express the wish to reverse the role from care giver to care receiver. This has been stated explicitly by some residents and has become evident in behavioral reaction of others.

All residents have some frailty to varying degrees. We have a group of "siblings" from all ethnic, cultural, socio-economic and religious backgrounds, with conflicting needs. Some are more capable than others and on different levels of Activities of Daily Living functioning. Some are more demanding, wanting total

care. As the social worker clinician began to establish relationships with individual residents, we became aware of the different ways some coped with feelings of emotional vulnerability.

Rosa, a frail 86 year old woman with loss of hearing, sight and deteriorating arthritic condition, was once a community leader, a fine pianist and accustomed to many cultural experiences. She became so demanding of assistance from staff and her peers that she eventually "turned off" everyone in the apartment. It was soon clear to the social worker that she was defending against a deep sense of humiliation at her decrease in Activities of Daily Living and the need for assistance from staff and residents. Her feelings of humiliation at her dependency produced anger and hostility which was acted out on an interpersonal level.

As the social worker clinician assesses each resident, behavior patterns emerge. Utilizing the understanding of dependence became a tool in fostering independence and eventually to help residents to learn how to be independent. Eventually, Rosa's experience became the basis for other residents to learn that to be independent, one must also be able to be dependent, in order to develop inter-dependent relationships.

With the awareness that group living is a new and different life style for the elderly, it is necessary to be creative and innovative. For a group of women who suffered early deprivation, our approach is to help them utilize ego strengths to adapt to group living, and increase and expand the quality of their life.

One of the ways we undertake to accomplish this is through group counseling. While the residents are encouraged to talk, reminisce, we also use poetry, photography and even finger painting. The women have the opportunity to develop

familiarity with one another and to recognize their similarity of experience even though their ethnic and religious backgrounds are quite different. Although there was an initial negative response to the group meetings, the women gradually experienced that they were no longer alone and isolated with their fears, anxiety and loss of physical, emotional and social function.

In addition to the group experience, individual counseling is also provided to help bridge the initial impact of the new life style of a group setting. The combination of group and individual counseling has been instrumental in helping these women retain their sense of self and in addition develop empathy and mutuality which has been a growth and enriching experience.

The concept of Enriched Housing is one model in providing for the long term care needs of the elderly. Not only does it offer this population an opportunity to be maintained in the community, but the nature of the program design, offers a mutual support system through the peer relationships as well as a professional support system, providing the opportunity to work towards a strengthening reintegration of social, emotional and environmental adaptive capabilities for the elderly.

Medical centers and health care agencies can play a unique and significant role in aiding the elderly population particularly those who are in the high risk category. It is important to recognize that as the population continues to age, the responsibility, whether willingly or not, to provide physical and emotional care will continue to fall heavily on health care institutions. There is now a growing receptivity amongst these agencies to deal with this situation. It behooves the health care professionals in such institutions to aid and participate with various levels of decision making groups to develop a comprehensive and integrative network of services. In order to facilitate the accessibility and

availability of such services to this population.

Through systematic documentation, careful presentation, and appropriate development of the services within the purview of the functions of the various hospitals and health care agencies, it is possible to develop purposeful and useful services. It is equally important for hospitals and health care agencies to become an integral part of the community network which offer services to the aged in the community so that coordination, cooperation and innovative programs can be developed without duplication or competition.

It has become clear that in today's highly technological society, Medical Centers can become the pivotal community base for the distribution of this network of services. They include health and mental health both on an in-patient and out-patient basis, and home care for those who are homebound. In addition there are a variety of community based programs which demonstrate the Medical Center's impact as a vital force in a network to sustain these frail aged in the community most expeditiously and effectively.

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